SOAH DOCKET NO. 453-04-5350.M2
TWCC MRD NO. M2-04-0942-01

AMERICAN HOME ASSURANCE COMPANY,	**§**	**BEFORE THE STATE OFFICE**
Petitioner	**§**	
	§	
V.	**§**	**OF**
	§	
ADVANTAGE HEALTHCARE SYSTEMS,	**§**	
Respondent	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

American Home Assurance Company (Carrier) challenged the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) authorizing Advantage Healthcare Systems (Provider) to administer a chronic pain management course to ___(Claimant). The MRD concluded that chronic pain management was medically necessary to treat Claimant.

Based on the evidence, Carrier met its burden of proof to show that a 30-session, multidisciplinary behavioral pain management course is not reasonable or medically necessary to treat Claimant's injury. Preauthorization for this program is denied.

The hearing in this matter convened on August 26, 2004, in Austin, Texas, with Administrative Law Judge (ALJ) Cassandra Church presiding. The record closed September 24, 2004, after the parties supplemented the record and filed closing argument. Provider was represented by Nick Kempisty, Provider's chief compliance officer. Carrier was represented at the hearing by Jim Korioth, attorney; Peter Mcaulay appeared as Carrier's representative post-hearing. The Commission did not participate in the hearing.

Matters of jurisdiction and notice were not disputed, so are set forth in the Findings of Fact and Conclusions of Law without further discussion here.

I. DISCUSSION

A. Background

On ___, Claimant injured suffered a T12 compression fracture and a lumbar strain in a fall. He was treated with physical therapy, trigger point injections, and a number of pain relief medications. In addition, he underwent thoracic epidural steroid injections in April 2003. On May 20, 2003, Claimant underwent a T12 percutaneous vertebroplasty, an injection of bone cement into the affected area in order to restore the original contours of the bone. This treatment was followed by physical therapy and continued medical treatment.

Notwithstanding the variety of treatments received during the year following his injury, Claimant continued to report ongoing back pain throughout the latter half of 2003. In December

2003, Kevin Kaufman, M.D., Claimant's surgeon, recommended Claimant undertake a comprehensive chronic pain management course to be administered by Provider. Dr. Kaufman had determined Claimant was not a good candidate for further surgical treatment to alleviate his symptoms.

Carrier denied preauthorization on the basis that the treatment was not medically necessary. In a decision issued on April 6, 2004, the MRD, acting through an Independent Review Organization, Maximus, authorized Provider to provide the requested treatment.

B. Standard for Chronic Pain Management Treatment

Provider's request for approval of this treatment occurred after the repeal of the 1996 *Medical Fee Guideline* (MFG).[1] However, neither the MRD decision nor the parties stated whether they had applied the MFG treatment standards by agreement, although some language in documents from the dispute at the Commission suggests that was the case. Neither party established that another treatment standard or guideline should or must be applied.[2] Thus, the ALJ relied on the expert medical testimony and medical records, but also consulted the terms of the 1996 MFG to arrive at a general framework of principles for appropriate treatment of chronic pain.[3]

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[1] *See* 1996 *Medical Fee Guideline* (MFG) 28 TEX. ADMIN. CODE § 134.201, Single and Interdisciplinary Programs, pp. 36-41 (repealed effective January 1, 2002).

[2] In making its recommendation against preauthorization, Carrier's utilization reviewer, Unimed Direct LLC, applied screening criteria of the American Psychiatric Association for malingering and the American Medical Association's literatureBtitles unspecifiedBregarding chronic pain syndrome. Carrier Exh. 1, p. 5. However, Carrier did not introduce these documents as evidence or establish the criteria therein to be applicable to the circumstances presented in this case.

Carrier did introduce several medical journal articles on treatment of back injuries through multidisciplinary programs. Carrier Exh. 2. Although informative, the articles ultimately proved to be of no benefit in disposing of this case as they do not address the issue of what would be medically necessary treatment for *Claimant.* Carrier did not establish that these articles described principles considered authoritative in the industry.

In materials sent to the IRO, Provider referenced a treatment standard or protocol that it apparently used in making its recommendation for a chronic pain management course. Provider Exh. 1, p. 23. However, this protocol itself was not in evidence nor did Provider establish that it was authoritative in the industry.

[3] The 1996 MFG set forth the following criteria for evaluation of the need for a chronic pain management course, and defined the treatment:

Chronic Pain Management: A program which provides a coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve functioning, and decrease the dependence on the health care system of persons with chronic pain syndrome.

1. Chronic pain syndrome is defined as any set of verbal and/or nonverbal behaviors that:

   a. involves the complaint of enduring pain;
   b. differs significantly from the injured worker's premorbid status;
   c. has not responded to previous appropriate medical, surgical, and/or injection treatment and
   d. interferes with the injured worker's physical, psychological, social, and/or vocation

C. Evidence

The Carrier relied on the testimony of Melissa Tonn, M. D., certified in occupational medicine, on medical examinations from 2003, and also on a surveillance tape and report of Claimant's activity level in January 2004. Provider relied on the recommendation of Dr. Kaufman and the evaluation by George Esterly, M.S., L.P.C., that Claimant would benefit from a pain management program.

Dr. Tonn stated that the only treatment now warranted for Claimant's condition would be over-the-counter pain relievers. She also stated she had found no functional or objective testing results that supported the medical need for an extensive multidisciplinary pain management program in January 2004. She also noted that Claimant had returned to work in spring of 2004 and had reached maximum medical improvement in May 2004, with a five per cent whole person impairment. Thus the period of need for such extensive treatment, if it ever existed, had passed.

Dr. Tonn also stated that not all doctors examining Claimant agreed that Claimant had suffered a T12 compression fracture. Notwithstanding that, compression fracture was the diagnosis under which the Carrier had authorized treatment for Claimant, including the vertebroplasty in May 2003. Dr. Tonn said Carrier had authorized the vertebroplasty in an abundance of caution and to give Claimant the benefit of the doubt on his reports of the severity of his pain.

Claimant apparently returned to work sometime in spring of 2004. On January 22, 2004, Claimant had been approved for return to work with modified duties.[4] In a physical examination conducted on November 24, 2003, at the Med-Alert Health Center, Claimant was able to flex and extend his back and to bend to both sides without pain or restriction. He also displayed normal upper and lower leg strength of five on a five-point scale and a normal gait.[5] His back was not tender.

For its medical case, Provider relied on the referral from Dr. Kaufman, who had performed the vertebroplasty. In a follow-up examination on December 18, 2003, Dr. Kaufman stated that Claimant had a good recovery from surgery, but continued to have significant muscle spasms in his lower back which were, at that time, nearly constant.[6] He recommended a "comprehensive" pain

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functioning.

2. Entrance/admission criteria shall enable the program to admit persons:

a. who are likely to benefit from this program design;
b. whose symptoms meet the above description of chronic pain syndrome; and
c. whose medical, psychological, or other conditions do not prohibit participation in program.

[4] Carrier Exh. 1, p. 192. Claimant had apparently been approved for return to work without restrictions in May 2003, but then was taken off work between September and December 2003. Carrier Exh. 1, pp. 136, 164-183.

[5] Carrier Exh. 1, p. 180.

[6] Provider Exh. 1, p. 6; Carrier Exh. 1, p. 163.

management program, but did not specifically recommend a 30-session, multidisciplinary program.

On January 15, 2004, Mr. Esterly concluded Claimant was a suitable candidate for the pain management program because Claimant had mastered neither pain or stress management nor learned how to focus on normal or wellness behavior, rather than on his pain.[7] At the time of Mr. Esterly's evaluation, Claimant reported feeling pain nearly 100 per cent of the time and experiencing difficulty with most activities of daily living, including driving, sleeping, household chores, and virtually any physical movement.

In addition to the medical evidence, Carrier also offered a surveillance tape, which it contended showed that Claimant's ability to walk, lift objects, and drive was not impaired. The tape was taken over a three-day period from January 10, 12, and 13, 2004, and was accompanied by a written report which covered more incidents than were taped.[8] The brief taped episodes captured Claimant moving a medium-sized flower pot, apparently full of soil, from a ledge on his balcony to the ground, driving his car to local business establishments, entering and exiting his car, carrying small grocery bags into his apartment, and discarding a small bag of trash. Provider's interpretation of the filmed activities differed from Carrier's, as it argued that the motions shown were not agile, but slow and guarded. Provider also argued that the videotape provided no context, i.e., whether Claimant could walk daily, or just on some days, and whether Claimant had taken his pain medication before leaving his apartment.

In the tape Claimant's gait and posture are not relaxed, but appear somewhat stilted, particularly as Claimant enters and exits his car. Nevertheless, he was walking freely, able to carry objects, and to lift down the filled flower pot. He was not using a cane in the video and rarely used one during the observation period, although he apparently had used a cane when he visited an industrial health clinic.[9] Without medical interpretation of the videotape, the contents were not conclusive in favor of either party. As Provider suggested, they were snapshots that offer little in the way of context. However, taken as a whole, the surveillance information tended to support other evidence Carrier presented.

D. Analysis and Conclusion

In late 2003 and early 2004, Claimant may have been experiencing, or perceiving, back pain as well as some degree of difficulty with some activities of daily living. However, the video of his activities, his return-to-work status and subsequent employment, as well as the medical evidence showing normal or near-normal functioning of his back in late 2003, demonstrated that Claimant has not failed entirely to respond to treatment.

Mr. Esterly's evaluation concluded that a major component of Claimant's difficulties was his lack of coping skills. The ALJ agrees that by late 2003 these concerns appear to have overtaken any lingering physical effects of his injury. However, Mr. Esterly's evaluation lacked credibility as it failed to explain why a 30-session, multidisciplinary program in particular would be necessary to

[7] Provider Exh. 1, pp. 17-30.

[8] Carrier Exhs. 1, pp. 106-115, and 3 (CD-ROM).

[9] Durable medical goods provided to Claimant included a walker and a cane. Carrier Exh. 1, pp. 4, 107-113.

enlarge Claimant's repertoire of coping skills, reduce his medication usage, or meet vocational goals. There was no indication the program offered was tailored to Claimant's needs or goals, or indeed what those specific goals might have been. In short, it was a generic prescription for such a program, and as such not persuasive.

While the ALJ cannot say that Claimant might not benefit-even now-from some kind of assistance in learning how to cope more effectively with his limitations, the contested case process does not present an opportunity to tailor a program.[10] On the issue that must be decided, preauthorization of a 30-week multidisciplinary behavioral pain management course, Carrier met its burden of proof to show that this course of treatment is not medically necessary to treat Claimant's compensable injury. Preauthorization is hereby denied.

II. FINDINGS OF FACT

1. On ___, ___(Claimant) suffered a compensable injury to his back in a fall. Claimant suffered a T12 compression fracture and lumbar strain.

2. American Home Assurance Company (Carrier) was the responsible insurer.

3. Immediately after the injury Claimant was treated with physical therapy, trigger point injections, and pain relief medications. In April 2003, Claimant underwent thoracic epidural steroid injections.

4. On May 20, 2003, Claimant underwent a T12 percutaneous vertebroplasty, followed by physical therapy and continued medical treatment.

5. Claimant recovered uneventfully from the surgery, but continued to experience back spasms through December 2003. Claimant was not a suitable candidate for additional surgery.

6. In December 2003, Claimant presented subjective complaints of pain and difficulty with activities of daily living. At that time he had not mastered pain or stress management or learned how to focus on normal or wellness behavior.

7. In December 2003, Kevin Kaufman, M.D., the surgeon who had performed the vertebroplasty, recommended that Claimant undertake a comprehensive pain management program. He did not specifically recommend a 30-session, multidisciplinary course.

8. In December 2003, Claimant was able to flex his back and extend his back forward and to both sides without pain or restriction. He also displayed upper and lower leg strength of five on a five-point scale and a normal gait. His back was not tender to the touch.

9. In January 2004, Claimant was able to drive his vehicle, carry or lift small packages or objects, and walk without a cane or other aid, although his ability to sustain those activities over time is unknown.

[10] The ALJ also has some concern about the staleness of the evidence concerning Claimant's condition. The most recent medical information dates from some eight months before the date of the hearing. Without knowing whether Claimant's condition, either mental or physical, is the same now as it was eight months ago, the ALJ is reluctant to preauthorize a program that may no longer be necessary, even had Claimant's condition warranted it in January 2004.

10. By January 22, 2004, Claimant was capable of working with modified duties.

11. Claimant returned to full-time work in spring of 2004.

12. In January 2004, Claimant had responded to medical treatment for his injury.

13. In January 2004, Provider requested preauthorization for a 30-session, multidisciplinary behavioral pain management for Claimant's treatment.

14. Provider did not identify the specific physical, psychological, social, or vocational functioning deficits Claimant demonstrated that he would be appropriately treated by the proposed pain management course, or how the proposed course would improve or resolve those deficits.

15. Carrier denied preauthorization for the chronic pain management treatment on the basis that it was not medically necessary.

16. Provider appealed the Carrier's denial of reimbursement to the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission).

17. On April 6, 2004, based on the review by an Independent Review Organization (IRO), Maximus, the MRD authorized the treatment.

18. On April 13, 2004, Carrier requested a hearing on the MRD decision on the preauthorization order.

19. On May 3, 2004, the Commission issued a notice of hearing that included the date, time, and location of the hearing, the applicable statutes under which the hearing would be conducted, and a short, plain statement of matters asserted. The case was continued on motion of the parties.

20. Administrative Law Judge Cassandra Church conducted a hearing on the merits of this case on August 26, 2004, and the record closed September 24, 2004, with the receipt of supplements to the record and closing arguments.

III. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031 and TEX. GOV'T CODE ANN. ch. 2003.

2. Carrier timely requested a hearing, as specified in 28 TEX. ADMIN CODE § 148.3.

3. Proper and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN.§§ 2001.051 and 2001.052.

4. Carrier, as the petitioning party, has the burden of proof in this proceeding pursuant to TEX. LAB. CODE ANN. § 413.031 and 28 TEX. ADMIN CODE § 148.21(h).

5. Carrier met its burden of proof to show that a 30-session, multidisciplinary course of behavioral pain management is not medically necessary to treat or reasonably required to relieve the effects of or promote recovery from the compensable injury suffered by Claimant, within the meaning of TEX. LAB. CODE ANN. §§ 408.021 and 401.011(19).

ORDER

IT IS ORDERED that preauthorization for Advantage Healthcare Systems to administer a 30-session, multidisciplinary course of behavioral pain management to ___(Claimant) is hereby denied.

SIGNED October 21, 2004.

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CASSANDRA J. CHURCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS